	FO	R OHF	USE		

LL1

2000 STATE OF ILLINOIS DEPARTMENT OF PUBLIC AID FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES (FISCAL YEAR 2000)

IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 LCS 4/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I.	IDPH Facility ID Number: 0038	794			II. CERTI	FICATION BY	AUTHORIZED FACILITY	OFFICER
	Facility Name: The Plum Grove of Palatino	e						
	Address: 24 S. Plum Grove Road	Palatine		60067	State of	f Illinois, for the		00 to 12/31/00
	Number	City	2	Zip Code			of my knowledge and belief the complete statements in accordance.	
	County: Cook				applica	ble instructions	. Declaration of preparer (otl	her than provider)
	Telephone Number: 847-358-0311	Fax # ()			is base	d on all informat	tion of which preparer has ar	ny knowledge.
	IDPA ID Number: 36-3898623						sentation or falsification of a be punishable by fine and/or	
	Date of Initial License for Current Owners:	08/01/93			Officer or	(Signed)		(Date)
	Type of Ownership:					(Type or Print	Name)	(Date)
	, Production Productio				of Provider			
	VOLUNTARY,NON-PROFIT	X PROPRIETARY	GOVI	ERNMENTAL		(Title)		
	Charitable Corp.	Individual		State				
	Trust	Partnership		County		(Signed) See A	ttached Accountant's Report	<u> </u>
	IRS Exemption Code	Corporation		Other				(Date)
		X "Sub-S" Corp.	_		Paid	(Print Name		
		Limited Liability Co.			Preparer	and Title)		
		Trust						
		Other				(Firm Name	Mendel S. Schneider & Asso	· · · · · · · · · · · · · · · · · · ·
						& Address)	6600 Lincoln Ave., Suite 330	0, Lincolnwood, Il. 60712
						(Telephone)	847-675-9311	Fax #847-675-9343
	Table and the control of the control	P					TO: OFFICE OF HEALTH	
	In the event there are further questions about the Name: Mendel S. Schneider	his report, please contact: Telephone Number: 847-675-93	311				NOIS DEPARTMENT OF PI . Grand Avenue East	UBLIC AID
	Traine Trends of Semether	100phone (value)	VII				gfield, IL 62763-0001	Phone # (217) 782-1630

STATE OF ILLINOIS Page 2

Facility Name & ID Number The Plum Grove	of Palatine		# 0038794 Report Period Beginning: 01/01/00 Ending: 12/31/00
III. STATISTICAL DATA			D. How many bed-hold days during this year were paid by Public Aid?
A. Licensure/certification level(s) of care	e; enter number of beds/bed days,		(Do not include bed-hold days in Section B.)
(must agree with license). Date of char	nge in licensed beds		
	_		E. List all services provided by your facility for non-patients.
1 2	3	4	(E.g., day care, "meals on wheels", outpatient therapy)
			None
Beds at		Licensed	
Beginning of Licensure	Beds at End of	Bed Days During	F. Does the facility maintain a daily midnight census? Yes
Report Period Level of Care	Report Period	Report Period	
	•	•	G. Do pages 3 & 4 include expenses for services or
1 69 Skilled (SNF)	69	25,254	1 investments not directly related to patient care?
2 Skilled Pediatric	c (SNF/PED)		2 YES NO X
3 Intermediate (IC	CF)		3
4 Intermediate/DE)		4 H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
5 Sheltered Care ((SC)		5 YES NO X
6 ICF/DD 16 or Le	ess		6
			I. On what date did you start providing long term care at this location?
7 69 TOTALS	69	25,254	7 Date started 08/01/93
			J. Was the facility purchased or leased after January 1, 1978?
B. Census-For the entire report period.		-	YES X Date 08/01/93 NO
1 2	3 4	5	77 XX
Level of Care Patient Days by L Public Aid	Level of Care and Primary Source of	Payment	K. Was the facility certified for Medicare during the reporting year?
	Private Pay Other	Total	YES X NO If YES, enter number of beds certified 5 and days of care provided 399
	Private Pay Other 1,384 399	3,277	of beds certified 5 and days of care provided 399
9 SNF/PED	1,384 399	3,277	
10 ICF 5,977	12,460	18,437	9 Medicare Intermediary Administar
11 ICF/DD	12,400	10,437	11 IV. ACCOUNTING BASIS
12 SC			12 MODIFIED
13 DD 16 OR LESS			13 ACCRUAL X CASH* CASH*
DE IV OR EESS			i necken k
14 TOTALS 7,471	13,844 399	21,714	14 Is your fiscal year identical to your tax year? YES X NO
	44 22 11 11 14 11 12		TD X/ 42/04 P! 1X/ 42/04
C. Percent Occupancy. (Column 5, line	14 divided by total licensed 85.98%		Tax Year: 12/31 Fiscal Year: 12/31 * All facilities other than governmental must report on the accrual basis.
bed days on line 7, column 4.)			* All tacilities other than governmental must report on the accrual basis

STATE OF ILL	INOIS			
#	0038794	Report Period Beginning:	01/01/00	

	Facility Name & ID Number	The Plum Grove			STATE OF ILI #	LINOIS 0038794	Report Period	Beginning:	01/01/00	Ending:	Page 3 12/31/00	_
	V. COST CENTER EXPENSES (through	phout the report,	please round to	the nearest do	llar)						TION ON THE	
	O (F		osts Per Genera	- 0	T ()	Reclass-	Reclassified	Adjust-	Adjusted	FOR OHI	F USE ONLY	
	Operating Expenses A. General Services	Salary/Wage	Supplies 2	Other 3	Total 4	ification 5	Total 6	ments 7	Total 8	9	10	
1	Dietary	122,431	6,810	5,005	134,246	3	134,246	,	134,246	,	10	1
2	Food Purchase	122,401	71,354	3,003	71,354	(3,500)	67,854	+	67,854		+	2
3	Housekeeping	50,981	33,513		84,494	(0,000)	84,494		84,494		+	3
4	Laundry	16,200	8,850		25,050		25,050		25,050		+	4
5	Heat and Other Utilities	10,200	0,000	42,592	42,592		42,592		42,592		+	5
6	Maintenance			44,276	44,276		44,276		44,276		+	6
7	Other (specify):*			,	,		,		,		+	7
8	TOTAL General Services	189,612	120,527	91,873	402,012	(3,500)	398,512		398,512		+	8
-	B. Health Care and Programs	107,012	120,327	71,675	402,012	(3,300)	370,312		370,312			÷
9	Medical Director			1,800	1,800		1,800		1,800			9
10	Nursing and Medical Records	912,186	71,982	3,990	988,158		988,158		988,158		+	10
	Therapy	712,100	.1,502	0,220	>00,100		>00,100		300,100		+	10a
11	Activities	39,796	5,224	2,851	47,871		47,871		47,871		+	11
12	Social Services	14,233	- /	,	14,233		14,233		14,233		†	12
13	Nurse Aide Training	,			,		,		,		+	13
14	Program Transportation										+	14
	Other (specify):*											15
16	TOTAL Health Care and Programs	966,215	77,206	8,641	1,052,062		1,052,062		1,052,062			16
	C. General Administration											
17	Administrative	108,243			108,243		108,243		108,243			17
18	Directors Fees											18
19	Professional Services			18,803	18,803		18,803		18,803			19
20	Dues, Fees, Subscriptions & Promotions			16,924	16,924	21,771	38,695	(11,850)	26,845			20
21	Clerical & General Office Expenses	28,236	19,945	22,034	70,215		70,215	(675)	69,540			21
22	Employee Benefits & Payroll Taxes			193,023	193,023	(18,271)	174,752		174,752			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,404	5,404		5,404		5,404			24
25	Other Admin. Staff Transportation									·		25
26	Insurance-Prop.Liab.Malpractice			40,522	40,522		40,522		40,522			26
27	Other (specify):*											27
28	TOTAL General Administration	136,479	19,945	296,710	453,134	3,500	456,634	(12,525)	444,109			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,292,306	217,678	397,224	1,907,208		1,907,208	(12,525)	1,894,683			29

**Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

The Plum Grove of Palatine

#0038794

Report Period Beginning:

01/01/00 Ending:

Page 4 12/31/00

V. COST CENTER EXPENSES (continued)

			Cost Per Gener	al Ledger		Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			29,853	29,853		29,853	44,986	74,839			30
31	Amortization of Pre-Op. & Org.							25,650	25,650			31
32	Interest							179,943	179,943			32
33	Real Estate Taxes			165,873	165,873		165,873		165,873			33
34	Rent-Facility & Grounds			221,377	221,377		221,377	(221,377)				34
35	Rent-Equipment & Vehicles			10,506	10,506		10,506		10,506			35
36	Other (specify):*											36
37	TOTAL Ownership			427,609	427,609		427,609	29,202	456,811			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			37,882	37,882		37,882		37,882			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			37,882	37,882		37,882		37,882	•		44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,292,306	217,678	862,715	2,372,699		2,372,699	16,677	2,389,376			45

^{*}Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

STATE OF ILLINOIS

Facility Name & ID Number The Plum Grove of Palatine

0038794

Report Period Beginning:

01/01/00

Ending:

Page 5 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	Amount	ŀ	2 Refer- ence	OHF USE ONLY	
1	Day Care	\$			\$	1
2	Other Care for Outpatients					2
3	Governmental Sponsored Special Programs					3
4	Non-Patient Meals					4
5	Telephone, TV & Radio in Resident Rooms					5
6	Rented Facility Space					6
7	Sale of Supplies to Non-Patients					7
8	Laundry for Non-Patients					8
9	Non-Straightline Depreciation	(13,1	44)	30		9
10		(9,9	60)	32		10
11	Discounts, Allowances, Rebates & Refunds					11
12	Non-Working Officer's or Owner's Salary					12
13	Sales Tax					13
14	Non-Care Related Interest					14
15	Non-Care Related Owner's Transactions					15
16	Personal Expenses (Including Transportation)					16
17	Non-Care Related Fees					17
18	Fines and Penalties					18
19	Entertainment					19
20	Contributions	(6	75)	21		20
21	Owner or Key-Man Insurance	,				21
22	Special Legal Fees & Legal Retainers					22
23	Malpractice Insurance for Individuals					23
24	Bad Debt					24
25		(11,8	50)	20		25
	Income Taxes and Illinois Personal Property Replacement Tax					26
27	Nurse Aide Training for Non-Employees					27
28	Yellow Page Advertising					28
	Other-Attach Schedule					29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (35,6	29)		\$	30

	OHF USE ONL	Y				
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2
		Amount	Reference
31	Non-Paid Workers-Attach Schedule*	\$	31
32	Donated Goods-Attach Schedule*		32
	Amortization of Organization &		
33	Pre-Operating Expense		33
	Adjustments for Related Organization		
34	Costs (Schedule VII)	52,306	34
35	Other- Attach Schedule		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 52,306	36
	(sum of SUBTOTALS		
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 16,677	37

^{*}These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

(See instructions)

(Se	e instructions.)	1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Page 5A

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference
1		s	1
2			2
3			3
4			4
5			5
6			7
7			
8			8
10			10
11			1
12			13
13 14			1.
15			1:
16			10
17			1
18			11
19			15
20			21
21			2
22			2:
23			2.
24			2-
25			2:
26			20
27			2'
28			2:
29			25
30			31
31	<u> </u>		3
32			3:
33			3.
34			3-
35			3:
36			31
37			3'
38			31
39			31
40			40
41			4
42			4:
43			4.
44			4-
45			4:
46			40
47			4
48			4:
49			4
50 51		+	5.
52			5.
53			5.
54			5
55			5:
56		1	50
57			5
58			5
59			5!
60	<u> </u>		60
61			6
62		1	6:
63		1	6.
64		1	6
65 66		1	6:
67		+	6
68		1	61
69		1	6
70		1	7
71			7
72			7.
73	·		7.
74			7-
75			7:
76			70
77		1	7
78 79		1	71
79 80		+	81
80 81		+	8
81 82		+	8
83		1	8.
84		1	8-
85		1	8:
86		1	80
87		1	8
88			8:
		1	8
89 90	Total	() 9

STATE OF ILLINOIS

Summary A Facility Name & ID Number The Plum Grove of Palatine
SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I # 0038794 Report Period Beginning: 01/01/00 12/31/00 **Ending:**

	SUMMARY OF PAGES 5, 5A, 6, 6A	A, 6B, 6C, 6D, 0	6E, 6F, 6G, 6H	I AND 6I									
													SUMMARY
	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6Н	6 I	(to Sch V, col.7)
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0 1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0 2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0 3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0 4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0 5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0 6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0 8
	B. Health Care and Programs												
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0 9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0 10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0 10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0 11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0 12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0 13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0 14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0 16
	C. General Administration												
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0 17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0 18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0 19
20	Fees, Subscriptions & Promotions	(11,850)	0	0	0	0	0	0	0	0	0	0	(11,850) 20
21	Clerical & General Office Expenses	(675)	0	0	0	0	0	0	0	0	0	0	(675) 21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0 22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0 23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0 24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0 25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0 26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 27
28	TOTAL General Administration	(12,525)	0	0	0	0	0	0	0	0	0	0	(12,525) 28
	TOTAL Operating Expense												
29	(sum of lines 8,16 & 28)	(12,525)	0	0	0	0	0	0	0	0	0	0	(12,525) 29

STATE OF ILLINOIS

Facility Name & ID Number The Plum Grove of Palatine # 0038794 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

													SUMMARY	
	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6 G	6H	6 I	(to Sch V, col	1.7)
30	Depreciation	(13,144)	58,130	0	0	0	0	0	0	0	0	0	44,986	30
31	Amortization of Pre-Op. & Org.	0	25,650	0	0	0	0	0	0	0	0	0	25,650	31
32	Interest	(9,960)	189,903	0	0	0	0	0	0	0	0	0	179,943	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(221,377)	0	0	0	0	0	0	0	0	0	(221,377)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(23,104)	52,306	0	0	0	0	0	0	0	0	0	29,202	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(35,629)	52,306	0	0	0	0	0	0	0	0	0	16,677	45

0038794

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

A. Enter below the names of ALE owners and related organizations (parties) as defined in the instructions. Attach an additional schedule in necessary.											
	2		3								
	RELATED NURSING HOM	IES	OTHER RELATED BUSINESS ENTITIES								
Ownership %	Name	Name	City	Type of Business							
	See Attached Schedule		Plum Properties	Palatine	Bldg. Rental						
	Ownership %	2 RELATED NURSING HOM	2 RELATED NURSING HOMES Ownership % Name City	2 RELATED NURSING HOMES OTHER REI Ownership % Name City Name	2 RELATED NURSING HOMES OTHER RELATED BUSINESS ENTIT Ownership % Name City Name City						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
1	V	34	Rent	\$ 221,377	Plum Grove Healthcare Properties, LLC.	100.00%	\$	\$ (221,377)	1
2	V	31	Amortization		Plum Grove Healthcare Properties, LLC.		25,650	25,650	2
3	V	32	Interest		Plum Grove Healthcare Properties, LLC.		189,903	189,903	3
4	V	30	Depreciation		Plum Grove Healthcare Properties, LLC.		58,130	58,130	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 221,377			s 273,683	\$ * 52,306	14

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number The Plum Grove of Palatine # 0038794 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	(5	7		8	
						Average Hou	rs Per Work				
					Compensation	Week Devo	oted to this	Compensati	on Included	Schedule V.	
					Received	Facility and	% of Total	in Costs		Line &	
				Ownership	From Other	Work Week		Reportin	g Period**	Column	
	Name	Title	Function	Interest	Nursing Homes*	Hours Percent		Description	Amount	Reference	
1	Tamar Abell	Asst. Administrator	Administrative	15.00	28,000	13.25	26.50	Salary	\$ 30,000	17-1	1
2	Joseph Brandman	Asst. Administrator	Administrative	7.50	55,475	8.5	17.25	Salary	27,897	17-1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 57,897		13

^{*} If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

^{**} This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).

FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

STATE OF ILLINOIS

Page 8

_ _ _

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1						\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23							ļ			23
24										24
25	TOTALS					\$	\$		\$	25

		STATE O	F ILLINOIS		Page 9
Facility Name & ID Number	The Plum Grove of Palatine	# 0038794	Report Period Beginning:	01/01/00 Ending:	12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	•	3	4	5	6	7	8	9	10	
	Name of Lender	Relate YES	ed** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Ai Origina	nount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related				•						•	
	Long-Term											
1	Pacific Life		X	Mortgage	\$18,448.00	11/17/95	\$ 2,220,0	00 \$ 2,086,156	11/17/15	8.0000	\$ 189,903	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				\$18,448.00		\$ 2,220,0	00 \$ 2,086,156			\$ 189,903	9
	B. Non-Facility Related*											
10	Interest Income		X								(9,960)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	s			\$ (9,960)	14
15	TOTALS (line 9+line14)						\$ 2,220,0	00 \$ 2,086,156			\$ 179,943	15

^{*} Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

^{**} If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

STATE OF ILLINOIS Page 10

AMOUNT TO USE FOR RATE CALCULATION \$

16

Facility Name & ID Number The Plum Grove of Palatine # 0038794 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes 166,639 1. Real Estate Tax accrual used on 1999 report. 2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.) 163,397 3. Under or (over) accrual (line 2 minus line 1). (3,242)4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.) 169,115 5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.) 5 6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.) 7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6. 165,873 Real Estate Tax History: Real Estate Tax Bill for Calendar Year: 1995 155,017 FOR OHF USE ONLY 159,032 1996 1997 162,112 FROM R. E. TAX STATEMENT FOR 1999 13 1998 161,004 11 163,397 PLUS APPEAL COST FROM LINE 5 14 1999 12 \$ Line 4: 163397 x 1.035 LESS REFUND FROM LINE 6 15 \$ 15

NOTES:

- 1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- If facility is a non-profit which pays real estate taxes, you must attach a denial of an
 application for real estate tax exemption unless the building is rented from a for-profit entity.
 This denial must be no more than four years old at the time the cost report is filed.

	ility Name & ID Number The Plum BUILDING AND GENERAL INFOL			STATE OF	ILLINOIS 0038794	Report Period Beginning:	01/01/0	0 Ending:	Page 11 12/31/00
		500 B. General Construction Type:	Exterior	Brick		Frame	Number of S	Stories	2
C.	1 5 ,	X (a) Own the Facility st complete Schedule XI. Those checking (c) m	(b) Rent from ay complete Schedul				(c) Rent from C Organization		related
D.	1 5 ,	X (a) Own the Equipment st complete Schedule XI-C. Those checking (c)	(b) Rent equip				(c) Rent equipm Unrelated O		npletely
Е.	(such as, but not limited to, apart	rned by this operating entity or related to the o tments, assisted living facilities, day training fa s, square footage, and number of beds/units av	cilities, day care, ind	dependent liv	•	0 0	,		
F.	Does this cost report reflect any of If so, please complete the following	organization or pre-operating costs which are l ng:	being amortized?			X YES	NO NO		
1	1. Total Amount Incurred:	392,725		2. Number	of Years O	ver Which it is Being Amor	rtized:	15	
	3. Current Period Amortization:	25,650		4. Dates Inc	curred:	06/17/95			

XI. OWNERSHIP COSTS:

Nature of Costs:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1995	\$ 179,021	1
2					2
3	TOTALS			\$ 179,021	3

re of Costs: Goodwill, Building Purchase
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

Page 12 12/31/00 Report Period Beginning: 01/01/00 Ending:

XI. OWNERS	HIP	COSTS	(con	tinue	ed)				

		ng Depreciation-Including Fixed Eq	uipment. (See instr	uctions.) Round	l all numbers to ne	arest dollar.					
	1		2	3	4	5	6	7	8	9	
		FOR OHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4	69		1995		\$ 966,189	\$ 24,774	39	\$ 24,774	\$	\$ 126,967	4
5											5
6											6
7											7
8											8
	Impro	vement Type**									
	Various Impr	ovements		1993	11,986	306	39	306		2,297	9
	Decorating			1993	17,180	439	39	439		3,296	10
	Decorating			1993	16,183	414	39	414		3,106	11
	Windows			1994	27,300	700	39	700		4,492	12
-	Air Condition			1994	29,179	748	39	748		4,924	13
	Air Condition	er		1994	4,300	110	39	110		724	14
	Painting			1994	3,725	96	39	96		632	15
16				1994	3,844	48	39	48		345	16
	Wallpaper			1995	7,000	179	39	179		1,025	17
18				1995	7,810	200	39	200		1,142	18
	Air Condition	er		1995	4,300	110	39	110		601	19
	Remodeling			1995	5,625	144	39	144		810	20
	Door Installat			1995	3,800	97	39	97		546	21
	Exhaust Vent	ilator		1996	3,564	91	39	91		406	22
	New Roof			1998	17,230	442	39	442		1,123	23
	Tilework			1998	4,248	109	39	109		277	24
25	Cummins Ger	nerator		1998	73,600	1,887	39	1,887		4,482	25
	Decorating			1998	54,647	1,401	39	1,401		3,911	26
	Floor			1999	16,855	432	39	432		669	27
	Remodeling			2000	6,276	87	39	87		87	28
29											29 30
30											31
31											32
33				 		+	1		ļ		33
34				<u> </u>		1	 				34
35				 		+	1		ļ		35
	TOTAL C:	og 4 thun 35)			6 1 204 041	e 22 01 4		e 22 01 4	6	6 1/1 9/3	
36	TOTAL (line	es 4 (NFU 35)		1	\$ 1,284,841	\$ 32,814		\$ 32,814	3	s 161,862	36

^{*}Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

C1	$\Gamma \Lambda \Gamma$	r Fr	UE	П	T	INO	TC

	STATE OF ILLINOIS						
Facility Name & ID Number	The Plum Grove of Palatine	#	0038794	Report Period Beginning:	01/01/00	Ending:	12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See in	instructions.
---	---------------

	C. Equipment Depreciation-Excitating Transportation. (See instructions.)									
	Category of	1		Current Book	Straight Line	4	Component	Accumulated		
	Equipment	Cost		Depreciation 2	Depreciation 3	Adjustments	Life 5	Depreciation 6		
37	Purchased in Prior Years	\$ 411,616	\$	37,890	\$ 41,161	\$ 3,271	10	\$ 227,874	37	
38	Current Year Purchases	17,279		17,279	864	(16,415)	10	864	38	
39	Fully Depreciated Assets								39	
40									40	
41	TOTALS	\$ 428,895	\$	55,169	\$ 42,025	\$ (13,144)		\$ 228,738	41	

D. Vehicle Depreciation (See instructions.)*

	1	Model, Make	Year	4	Current Book	Straight Line	7	Life in	Accumulated	
	Use	and Year 2	Acquired 3	Cost	Depreciation 5	Depreciation 6	Adjustments	Years 8	Depreciation 9	
42				\$	\$	\$	\$	\$		42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$	\$		46

F Summary of Cara-Related Assets

	L. Summary of Care-Related Assets	1	L		
		Reference	Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 1,892,757	47	7
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 87,983	48	}
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 74,839	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ (13,144	1) 50)
51	Accumulated Depreciation	(line 36.col.9 + line 41.col.6 + line 46.col.9)	\$ 390,600	51	П

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1	2	Current Book	Accumulated	
	Description & Year Acquired	Cost	Depreciation 3	Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

This must agree with Schedule V line 30, column 8.

STATE OF ILLINOIS

Page 14

Facility Name & ID Number The Plum Grove of Palatine 0038794 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00 XII. RENTAL COSTS A. Building and Fixed Equipment (See instructions.) 1. Name of Party Holding Lease: 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. YES NO 2 3 5 Year Number Date of Rental **Total Years Total Years** Constructed Renewal Option* of Beds Lease Amount of Lease Original 10. Effective dates of current rental agreement: 3 Building: 3 4 4 Additions Ending 5 5 6 6 11. Rent to be paid in future years under the current 7 TOTAL rental agreement: 8. List separately any amortization of lease expense included on page 4, line 34. Fiscal Year Ending **Annual Rent** This amount was calculated by dividing the total amount to be amortized by the length of the lease /2002 /2003 YES 9. Option to Buy: Terms: B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.) 15. Is Movable equipment rental included in building rental? YES NO 16. Rental Amount for movable equipment: \$ **Description:** (Attach a schedule detailing the breakdown of movable equipment) C. Vehicle Rental (See instructions.) **Monthly Lease** Model Year **Rental Expense** for this Period * If there is an option to buy the building, Use and Make Payment 17 17 Facility please provide complete details on attached Town & Country Van 468.99 5,628 18 Facility Sebring 440.00 4,878 18 schedule. 19 19 20 20 ** This amount plus any amortization of lease 21 TOTAL 908.99 10,506 21 expense must agree with page 4, line 34.

			S	STATE OF ILLI	NOIS						Page 15
	ame & ID Number The Plum Grove of Pa				#	0038794	Report Perio	od Beginning:	01/01/00	Ending:	12/31/00
XIII. EXP	PENSES RELATING TO NURSE AIDE TRAINING 1	PROGRAMS (See in	structions.)								
	VIDE OF ED A DAVIG DO CD AND AS A										
A. T	YPE OF TRAINING PROGRAM (If aides are trained	d in another facility	program, attach a	schedule listing t	the facility	name, addre	ss and cost per	aide trained in th	at facility.)		
	1. HAVE YOU TRAINED AIDES	YES 2.	. CLASSROOM	PORTION:			3.	CLINICAL PO	RTION:		
	DURING THIS REPORT		CLISSICONI	TORTION			٠.	CERTORETOR		_	
	PERIOD?	X NO	IN-HOUSE PR	ROGRAM				IN-HOUSE PRO	OGRAM		
			IN OTHER FA	CILITY				IN OTHER FAC	CILITY		
	If "yes", please complete the remainder										
	of this schedule. If "no", provide an		COMMUNITY	COLLEGE				HOURS PER A	IDE		
	explanation as to why this training was		HOURS PER A	LIDE							
	not necessary.		HOURS PER A	AIDE							
D E	XPENSES						C CO	NTRACTUAL IN	COME		
В. Е.	APENSES	ALLOCATI	ON OF COSTS	(d)			c.co	NIKACIUAL IN	COME		
		ALLOCATI	ON OF COSTS	(u)				In the box below	v record the a	mount of i	ncome vour
		1	2	3		4		facility received			
		Fa	cility						g		
		Drop-outs	Completed	Contract		Total		\$			
	Community College Tuition	\$	\$	\$	\$					-	
	Books and Supplies						D. NUI	MBER OF AIDES	TRAINED		
	Classroom Wages (a)										
	Clinical Wages (b)							COMPLET			
5	In-House Trainer Wages (c)							1. From this faci	ility		
6	Transportation							2. From other fa	cilities (f)		
7	Contractual Payments							DROP-OUT	TS .		
8	Nurse Aide Competency Tests							1. From this faci	ility		

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.

(e)

TOTALS

SUM OF line 9, col. 1 and 2

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

2. From other facilities (f)

TOTAL TRAINED

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Report Period Beginning: # 0038794

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

The Plum Grove of Palatine

Facility Name & ID Number

	(STECHE CERTICES (Effect cost)	1	2	3	4	5	6	7	8	
		Schedule V	Staff	f	Outsid	le Practitioner	Supplies			
	Service	Line & Column	Units of	Cost	(other th	han consultant)	(Actual or)	Total Units	Total Cost	
		Reference	Service		Units	Cost	Allocated)	(Column 2 + 4)	(Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	\$		\$	\$!	8	1
	Licensed Speech and Language									
2	Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
			# of							
9	Pharmacy		prescrpts							9
	Psychological Services									
	(Evaluation and Diagnosis/									
10	Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$!	8	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

XV. BALANCE SHEET - Unrestricted Operating Fund.
This report must be completed even if financial statements are attached. As of 12/31/00 (last day of reporting year)

		1			2 After		
		OI	perating	C	onsolidation*		
	A. Current Assets						
1	Cash on Hand and in Banks	\$	229,589	\$	231,070	1	
2	Cash-Patient Deposits					2	
	Accounts & Short-Term Notes Receivable-						
3	Patients (less allowance		144,507		144,507	3	
4	Supply Inventory (priced at					4	
5	Short-Term Investments					5	
6	Prepaid Insurance		56,348		56,348	6	
7	Other Prepaid Expenses					7	
8	Accounts Receivable (owners or related parties)					8	
9	Other(specify): Real Estate Escrow		101,774			9	
	TOTAL Current Assets						
10	(sum of lines 1 thru 9)	\$	532,218	\$	431,925	10	
	B. Long-Term Assets						
11	Long-Term Notes Receivable					11	
12	Long-Term Investments					12	
13	Land				179,021	13	
14	Buildings, at Historical Cost				966,189	14	
15	Leasehold Improvements, at Historical Cost		318,653		318,653	15	
16	Equipment, at Historical Cost		83,894		428,895	16	
17	Accumulated Depreciation (book methods)		(108,956)		(530,888)	17	
18	Deferred Charges					18	
19	Organization & Pre-Operating Costs				392,725	19	
	Accumulated Amortization -						
20	Organization & Pre-Operating Costs				(139,380)	20	
21	Restricted Funds					21	
22	Other Long-Term Assets (specify):					22	
23	Other(specify): Due from Owners				99,305	23	
	TOTAL Long-Term Assets						
24	(sum of lines 11 thru 23)	\$	293,591	\$	1,714,520	24	
	TOTAL ASSETS						
25	(sum of lines 10 and 24)	\$	825,809	\$	2,146,445	25	

		1 O _I	perating	2 After onsolidation*	
	C. Current Liabilities				
26	Accounts Payable	\$	120,706	\$ 120,706	26
27	Officer's Accounts Payable				27
28	Accounts Payable-Patient Deposits				28
29	Short-Term Notes Payable				29
30	Accrued Salaries Payable		51,371	51,371	30
	Accrued Taxes Payable				
31	(excluding real estate taxes)		5,552	5,552	31
32	Accrued Real Estate Taxes(Sch.IX-B)		169,115	169,115	32
33	Accrued Interest Payable			11,382	33
34	Deferred Compensation				34
35	Federal and State Income Taxes				35
	Other Current Liabilities(specify):				
36					36
37					37
	TOTAL Current Liabilities				
38	(sum of lines 26 thru 37)	\$	346,744	\$ 358,126	38
	D. Long-Term Liabilities				
39	Long-Term Notes Payable				39
40	Mortgage Payable			2,086,156	40
41	Bonds Payable				41
42	Deferred Compensation				42
	Other Long-Term Liabilities(specify):				
43					43
44					44
	TOTAL Long-Term Liabilities				
45	(sum of lines 39 thru 44)	\$		\$ 2,086,156	45
	TOTAL LIABILITIES				
46	(sum of lines 38 and 45)	\$	346,744	\$ 2,444,282	46
	,				
47	TOTAL EQUITY(page 18, line 24)	\$	479,065	\$ (297,837)	47
	TOTAL LIABILITIES AND EQUITY		,	` ′ ′	
48	(sum of lines 46 and 47)	\$	825,809	\$ 2,146,445	48

^{*(}See instructions.)

Facility Name & ID Number The Plum Grove of Palatine
XVI. STATEMENT OF CHANGES IN EQUITY

0038794

Report Period Beginning: 01/01/00

Ending:

	1 Total	
1 Balance at Beginning of Year, as Previously Reported	\$ 436,040	1
2 Restatements (describe):		2
3		3
4		4
5		5
6 Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 436,040	6
A. Additions (deductions):		
7 NET Income (Loss) (from page 19, line 43)	143,025	7
8 Aquisitions of Pooled Companies		8
9 Proceeds from Sale of Stock		9
10 Stock Options Exercised		10
11 Contributions and Grants		11
12 Expenditures for Specific Purposes		12
13 Dividends Paid or Other Distributions to Owners	(100,000)	13
14 Donated Property, Plant, and Equipment		14
15 Other (describe)		15
16 Other (describe)		16
17 TOTAL Additions (deductions) (sum of lines 7-16)	\$ 43,025	17
B. Transfers (Itemize):		
18		18
19		19
20		20
21		21
22		22
23 TOTAL Transfers (sum of lines 18-22)	\$	23
24 BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 479,065	24

^{*} This must agree with page 17, line 47.

01/01/00

Page 19 **Ending:** 12/31/00

Report Period Beginning: XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached. Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue		Amount	
	A. Inpatient Care			
1	Gross Revenue All Levels of Care	\$	2,505,764	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$	2,505,764	3
	B. Ancillary Revenue			
4	Day Care			4
5	Other Care for Outpatients			5
6	Therapy			6
7	Oxygen			7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$		8
	C. Other Operating Revenue			
9	Payments for Education			9
10	Other Government Grants			10
11	Nurses Aide Training Reimbursements			11
12	Gift and Coffee Shop			12
13	Barber and Beauty Care			13
14	Non-Patient Meals			14
15	Telephone, Television and Radio			15
16	Rental of Facility Space			16
17	Sale of Drugs			17
18	Sale of Supplies to Non-Patients			18
19	Laboratory			19
20	Radiology and X-Ray			20
21	Other Medical Services			21
22	Laundry			22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$		23
	D. Non-Operating Revenue			
	Contributions			24
	Interest and Other Investment Income***		9,960	25
26		\$	9,960	26
	E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)			27
28				28
28a				28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$		29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$	2,515,724	30

			2	
	Expenses		Amount	
	A. Operating Expenses			
31	General Services		402,012	31
32	Health Care		1,052,062	32
33	General Administration		453,134	33
	B. Capital Expense			
34	Ownership		427,609	34
	C. Ancillary Expense			
35	Special Cost Centers			35
36	Provider Participation Fee		37,882	36
	D. Other Expenses (specify):			
37				37
38				38
39				39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$	2,372,699	40
70	101AL EAT ENSES (sum of mics 31 tin u 37)	Φ	2,372,077	70
41	Income before Income Taxes (line 30 minus line 40)**		143,025	41
42	Income Taxes			42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$	143,025	43

*	This must	t agree with	page 4,	line 45,	column 4.
---	-----------	--------------	---------	----------	-----------

Does this agree with taxable income (loss) per Federal Income Yes If not, please attach a reconciliation. Tax Return?

^{***} See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

^{****}Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number The Plum Grove of Palatine

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	•	1	2**	3	4	
		# of Hrs.	# of Hrs.	Reporting Period	Average	
		Actually	Paid and	Total Salaries,	Hourly	
		Worked	Accrued	Wages	Wage	
1	Director of Nursing	960	1,099	\$ 24,325	\$ 22.13	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,512	14,647	243,241	16.61	3
4	Licensed Practical Nurses	6,379	6,768	115,658	17.09	4
5	Nurse Aides & Orderlies	39,642	41,301	513,277	12.43	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,006	4,289	39,796	9.28	10
11	Social Service Workers	1,072	1,166	14,233	12.21	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,102	31,072	14.78	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,458	12,195	91,359	7.49	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	6,822	7,357	50,981	6.93	18
19	Laundry	2,014	2,178	16,200	7.44	19
20	Administrator	2,080	2,320	50,346	21.70	20
21	Assistant Administrator	3,790	3,797	57,897	15.25	21
22	Other Administrative					22
23	Office Manager					23
	Clerical	2,110	2,363	28,236	11.95	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,000	2,080	15,685	7.54	31
32	Other Health Care(specify)	ĺ	ĺ	,		32
	Other(specify)					33
34	TOTAL (lines 1 - 33)	97,925	103,662	s 1,292,306 *	s 12.47	34

^{*} This total must agree with page 4, column 1, line 45.

B. CONSULTANT SERVICES

		1	2	3	
		Number	Total Consultant	Schedule V	
		of Hrs.	Cost for	Line &	
		Paid &	Reporting	Column	
		Accrued	Period	Reference	
35	Dietary Consultant	120	\$ 5,005	1-3	35
36	Medical Director	60	1,800	9-3	36
37	Medical Records Consultant	30	825	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	84	3,165	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	66	2,851	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	360	s 13,646		49

C. CONTRACT NURSES

		1	2	3	
		Number		Schedule V	
		of Hrs.	Total	Line &	
		Paid &	Contract	Column	
		Accrued	Wages	Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

^{**} See instructions.

STATE OF ILLINOIS Page 21

Name Function % Amount Barbara Davis Administrator 0 \$50,346 Workers' Compensation Insurance \$22,962 IDPH License Fee \$200 Tamar Abell Asst Administrator 15.00 30,000 Unemployment Compensation Insurance 7,840 Advertising: Employee Recruitment 21,771 Joseph Brandman Asst Administrator 7.50 27,897 FICA Taxes 90,988 Health Care Worker Background Check Employee Health Insurance 49,462 (Indicate # of checks performed) Employee Meals 3,500 Advertising 11,850 Employee Meals 3,500 Advertising 11,850 Illinois Municipal Retirement Fund (IMRF)* Daily Herald 1,331 TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.) \$108,243	Facility Name & ID Number	The Plum Grove of	Palatine			# 0038794		Rep	ort Period	Beginning:	01/01/00	Ending:	1	2/31/00
	A. Administrative Salaries Name		%			Description					Description		A	
Fig. 2, 20,18 Fig. 2, 20,1				\$				\$					<u> </u>	
Employee Health Insurance							surance						_	21,771
Employee Meak Illinois Municipal Retirement Fund (IMRF)* ICLTC-Dues 2,708 2,	Joseph Brandman	Asst Administrator	7.50		27,897									
Illinois Municipal Retirement Fund (IMRF)* CLTC-Does 2,705 Daily Herald 1,331 Misc Subs 388 List each licensed administrator separately.) S 108,243 Description Amount Description S Description S		<u> </u>				1 2				,		<u>d</u>)		
Daily Herald 1,331		<u> </u>				1 3			3,500		2			
Misc Subs 838						Illinois Municipal Retirement Fun	nd (IMRF)*			ICLTC-Du	es			2,705
List each licensed administrator separately.) B. Administrative - Other Description Amount TOTAL (agree to Schedule V, line 17, col. 3) C. Professional Services Vendor/Payee Type Amount Vendor/Payee Type Amount Vendor/Payee Type Amount Vendor/Payee Type Amount Vendor/Payee Terrence Kennedy Real Estate Lawyer Spessoned Planners UC Cosultant Accounting 1,463 Line 27, col. 3) TOTAL (agree to Schedule V, line 18, col. 3) Total (agree to Schedule V, line 19, column 3)								_		Daily Hera	ld			1,331
B. Administrative - Other Description Amount TOTAL (agree to Schedule V, ine 17, col. 3) (Attach a copy of any management service agreement) C. Professional Services Vendor/Payee Type Amount Mendel S. Schneider Accounting S. 7,800 Person, Ruttenberg, Rothblatt Accounting S. 7,800 Personnel Planners UC Cnsultant 1,463 UC Cnsultant 1,463 TOTAL (agree to Schedule V, ine 17, col. 3) S. 6,564 Description Description Line # Amount Amount Amount Description Description Description Description Line # Amount Description Description Description Description Description Amount Description Description Description Description Amount Description Amount Description Descriptio										Misc Subs				838
Description Amount S Amount Accopy of any management service agreement) C C Professional Services Vendor/Payee Accounting S 7,800 Amount Accounting S 7,800 Bescription Amount Accounting S Amount Accounting S 7,800 Bescription Amount Accounting S Amount Accounting S Amount Accounting S 7,800 Bescription Amount Accounting S Amount Accounting S Amount Accounting S Amount Bescription Amount Accounting S Amount Accounting S Amount Accounting S Amount Bescription Amount Accounting S Amount Accounting S Amount Accounting S Amount Bescription Amount Accounting S Bescription Amount Accounting Amount Account	(List each licensed administrator	separately.)		\$	108,243									
Description Amount TOTAL (agree to Schedule V, line 17, col. 3) Amount TOTAL (agree to Schedule V, line 17, col. 3) Amount TOTAL (agree to Schedule V, line 17, col. 3) Amount Vendor/Payee Type Amount Description Description Line # Amount Description Description Description Amount Description Description Description Line # Amount Description Description In-State Travel In-State Trav	B. Administrative - Other													
TOTAL (agree to Schedule V, line 17, col. 3) Saction of the properties of the pr										Less: Pul	olic Relations Expens	se (
TOTAL (agree to Schedule V, line 17, col. 3) Saction of the properties of the pr	Description				Amount					Non	-allowable advertisi	ng		(11,850)
Ine 22, col.8 Ine 20, col.8 Ine	•			\$				-						<u> </u>
Ine 22, col.8 Ine 20, col.8 Ine					-						100	`		
Ine 22, col.8 Ine 20, col.8 Ine						TOTAL (agree to Schedule V.		\$	174,752		TOTAL (agree to S	Sch. V.	5	26,845
E. Schedule of Non-Cash Compensation Paid to Owners or Employees Description Amount						` ` `					(0		_	
Attach a copy of any management service agreement) C. Professional Services Vendor/Payee Type Amount Mendel S. Schneider Accounting S. 7,800 Frost, Ruttenberg, Rothblatt Accounting Real Estate Lawyer Personnel Planners UC Cnsultant I,463 In-State Travel	TOTAL (agree to Schedule V. lin	ne 17. col. 3)	·	\$			sation Paid			G. Schedu				
C. Professional Services Vendor/Payee Type Amount Description Line # Amount Out-of-State Travel S Frost, Ruttenberg, Rothblatt Ferrence Kennedy Real Estate Lawyer Personnel Planners UC Cnsultant 1,463 In-State Travel In-St	, 0		`	*		_								
Vendor/Payee Type Amount Mendel S. Schneider Accounting \$ 7,800 S Out-of-State Travel \$		nt ser vice agreement	,			to owners or Employees					Description		Δ	mount
Mendel S. Schneider Accounting S 7,800 S Out-of-State Travel S Frost, Ruttenberg, Rothblatt Accounting S, 3,884 Ferrence Kennedy Real Estate Lawyer S, 656 Personnel Planners UC Cnsultant I,463 In-State Travel Seminar Expense II Council Long Term Care S,404 FOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.) S 18,803 TOTAL S 0ut-of-State Travel In-State Travel Seminar Expense II Council Long Term Care (agree to Sch. V, TOTAL line 24, col. 8) S 5,404		Type			Amount	Description	Line#		Amount		Description		1	inount
Frost, Ruttenberg, Rothblatt Accounting Real Estate Lawyer S,656 Personnel Planners UC Cnsultant 1,463 In-State Travel Seminar Expense Il Council Long Term Care S,404 FOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.) S 18,803 TOTAL S Entertainment Expense (agree to Sch. V, TOTAL line 24, col. 8) S,5,404	·			e		Description	Line "	·	Amount	Out-of-Sto	to Travel		2	
Terrence Kennedy Personnel Planners UC Cnsultant 1,463 In-State Travel Seminar Expense Il Council Long Term Care 5,404 TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.) S ta,803 TOTAL S TOT				Φ				Ψ.		Out-or-sta	it Havei			
Personnel Planners UC Cnsultant 1,463 In-State Travel Seminar Expense Il Council Long Term Care 5,404 FOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.) \$ 18,803 In-State Travel Seminar Expense (agree to Schedule V, line 19, column 3) (agree to Sch. V, TOTAL line 24, col. 8) TOTAL line 24, col. 8) \$ 5,404											_			
Seminar Expense Il Council Long Term Care 5,404 FOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.) 18,803 TOTAL \$ Entertainment Expense (agree to Sch. V, TOTAL line 24, col. 8) 5,404	<u> </u>		yer							I., C4.4. T	1		_	
Il Council Long Term Care 5,404 Council Long Term Care 5,404	Personnel Planners	UC Cusuitant			1,463					In-State 1	ravei		_	
Il Council Long Term Care 5,404 Council Long Term Care 5,404											_		_	
Il Council Long Term Care 5,404 Council Long Term Care 5,404											_		_	
Il Council Long Term Care 5,404 Council Long Term Care 5,404							-						_	
TOTAL (agree to Schedule V, line 19, column 3) If total legal fees exceed \$2500 attach copy of invoices.) TOTAL S Entertainment Expense (agree to Sch. V, TOTAL line 24, col. 8) S 5,404							-						_	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.) **TOTAL** (agree to Sch. V, TOTAL** TOTAL** TOTAL** TOTAL** TOTAL* 11										Il Council	Long Term Care			5,404
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.) **TOTAL** (agree to Sch. V, TOTAL** TOTAL** TOTAL** TOTAL** TOTAL* 11										Entertein	nent Evnense		_	
				٠		TOTAL		\$			(agree to Sch.			,
	(If total legal fees exceed \$2500 a	ttach copy of invoices	s.)	\$	18,803	1					,	8)	§	5,404

^{*} Attach copy of IMRF notifications

^{**}See instructions.

		STATE OF ILLINOIS				Page 22
Facility Name & ID Number	The Plum Grove of Palatine	# 0038794	Report Period Reginning	01/01/00	Ending	12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

	(See instructions.)												
	1	2	3	4	5	6	7	8	9	10	11	12	13
	_	Month & Year						Amount of	Expense Amor	tized Per Year			
	Improvement	Improvement	Total Cost	Useful	EX.400#	EXILORO	EX.4000	EX.2000	EX.2004	EX.2002	EX.2002	EX.2004	EN /200#
-	Туре	Was Made		Life	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17	·												
18	<u>-</u>												
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility	S' y Name & ID Number	TATE (#	OF ILLINOIS 0038794	Report Period Beginning:	01/01/00	Ending:	Page 23 12/31/00
	ENERAL INFORMATION:			1 0			
	Are nursing employees (RN,LPN,NA) represented by a union?	(13)		supplies and services which are of the Public Aid, in addition to the daily r			
(2)	Are there any dues to nursing home associations included on the cost report? Yes If YES, give association name and amount. ICLTC-2705		in the Ancillary Se	ction of Schedule V? Yes	_		
(3)	Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report?	, ,	the patient census lis a portion of the b	ouilding used for any function other isted on page 2, Section B? No ouilding used for rental, a pharmacy, xplains how all related costs were al	day care, etc.)	For example If YES, attac	e,
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity?		Indicate the cost of on Schedule V. related costs?		ssified to employ meal income be the amount.	oeen offset ag	ainst
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period? Yes 39		Travel and Transpo	ortation ncluded for out-of-state travel?	No		
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,500 Line 10		If YES, attach a	complete explanation. eparate contract with the Departmen	t to provide me		
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.		program during c. What percent of	this reporting period. \$ N/A all travel expense relates to transporage logs been maintained? No			
(8)	Are you presently operating under a sale and leaseback arrangement? No If YES, give effective date of lease.		e. Are all vehicles times when not i	stored at the nursing home during th n use? No			
(9)	Are you presently operating under a sublease agreement? YES X NO		out of the cost re	commuting or other personal use of a port? No ty transport residents to and fr	_		NY.
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.		Indicate the a	mount of income earned from p n during this reporting period.	providing suc		No
	N/A		Firm Name: N/		_	The instruct	No tions for the
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 37,882 This amount is to be recorded on line 42 of Schedule V.		cost report require been attached?	that a copy of this audit be included If no, please explain.	with the cost re	eport. Has thi	s copy
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.		Have all costs which out of Schedule V?	ch do not relate to the provision of lo	ong term care b	een adjusted o	out
	<u> </u>		performed been att	re in excess of \$2500, have legal invalence to this cost report? Yes d a summary of services for all archi		·	ices